STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING _____ B. WING _____	R-C 05/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH NURSING HOME	**701 S OAK STREET WINCHESTER, IN 47394**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 4/6/11. This visit included the PSR to the investigation of complaint # IN00087993 completed on 4/6/11. Complaint # IN00087993: Corrected. Survey Dates: May 24, 25, 2011 Facility number: 000136 Provider number: 155231 AIM number: 100275450 Survey Team: Tammy Alley RN TC Toni Maley BSW Donna M. Smith RN Census bed type: SNF/NF: 76 Total: 76 Census payor type: Medicare: 20 Medicaid: 49 Other: 7 Total: 76 Sample: 10 Randolph Nursing Center was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to the investigation of complaint # IN00087993.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING _____ B. WING _____	R-C 05/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH NURSING HOME	**701 S OAK STREET WINCHESTER, IN 47394**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Quality review completed 5-26-11 Cathy Emswiller RN	{F 000}		